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75801-75803

75801  Lymphangiography, extremity only, unilateral, radiological supervision and interpretation
75803  Lymphangiography, extremity only, bilateral, radiological supervision and interpretation

ICD-9-CM Procedural
88.34  Lymphangiogram of upper limb
88.36  Lymphangiogram of lower limb

Anesthesia
N/A

ICD-9-CM Diagnostic
196.9  Secondary and unspecified malignant neoplasm of lymph nodes, site unspecified
200.00 Reticulosarcoma, unspecified site, extranodal and solid organ sites
200.10 Lymphosarcoma, unspecified site, extranodal and solid organ sites
201.50 Hodgkin’s disease, nodular sclerosis, unspecified site, extranodal and solid organ sites
201.54 Hodgkin’s disease, nodular sclerosis, of lymph nodes of axilla and upper limb
201.56 Hodgkin’s disease, nodular sclerosis, of intrathoracic lymph nodes
201.57 Hodgkin’s disease, nodular sclerosis, of spleen
201.58 Hodgkin’s disease, nodular sclerosis, of lymph nodes of multiple sites
201.60 Hodgkin’s disease, mixed cellularity, unspecified site, extranodal and solid organ sites
201.64 Hodgkin’s disease, mixed cellularity, of lymph nodes of axilla and upper limb
201.68 Hodgkin’s disease, mixed cellularity, of lymph nodes of multiple sites
201.70 Hodgkin’s disease, lymphocytic depletion, unspecified site, extranodal and solid organ sites
201.74 Hodgkin’s disease, lymphocytic depletion, of lymph nodes of axilla and upper limb
201.78 Hodgkin’s disease, lymphocytic depletion, of lymph nodes of multiple sites
201.90 Hodgkin’s disease, unspecified type, unspecified site, extranodal and solid organ sites
201.94 Hodgkin’s disease, unspecified type, of lymph nodes of axilla and upper limb
201.98 Hodgkin’s disease, unspecified type, of lymph nodes of multiple sites
202.00 Nodular lymphoma, unspecified site, extranodal and solid organ sites
202.04 Nodular lymphoma of lymph nodes of axilla and upper limb
202.08 Nodular lymphoma of lymph nodes of multiple sites
202.10 Mycosis fungoides, unspecified site, extranodal and solid organ sites
202.14 Mycosis fungoides of lymph nodes of axilla and upper limb
202.18 Mycosis fungoides of lymph nodes of multiple sites
202.20 Sezary’s disease, unspecified site, extranodal and solid organ sites
202.24 Sezary’s disease of lymph nodes of axilla and upper limb
202.28 Sezary’s disease of lymph nodes of multiple sites
202.74 Peripheral T-cell lymphoma, lymph nodes of axilla and upper limb
202.80 Other malignant lymphomas, unspecified site, extranodal and solid organ sites
202.84 Other malignant lymphomas of lymph nodes of axilla and upper limb
202.90 Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue, unspecified site, extranodal and solid organ sites
202.94 Other and unspecified malignant neoplasms of lymphoid and histiocytic tissue of lymph nodes of axilla and upper limb
683  Acute lymphadenitis — (Use additional code to identify organism: 041.1)
785.6  Enlargement of lymph nodes

CCI Version 16.3
01916, 01924-01926, 36005, 76000-76001, 76350, 76942, 76998, 77002, 96372
Also not with 75803: 75801
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

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Medicare References: 100-2,15,80; 100-4,3,10,4; 100-4,12,30; 100-4,13,10; 100-4,13,100

Explanation
Vital blue dye is injected into the subcutaneous tissues for outlining of skin lymphatics. As soon as the lymphatic vessels are visualized by their blue color, the physician makes a small incision to gain access. The lymph vessel is cannulated with a needle and a fine catheter is attached. A small amount of dye is injected to ensure correct placement and the needle is advanced a few millimeters into the vessel. The needle and catheter are secured and dye is injected with a syringe. X-rays are made. Code 75801 reports the radiological supervision and interpretation for lymphangiography of an extremity on one side only; 75803 reports the radiological supervision and interpretation for lymphangiography of extremities on both sides. Use a separately reportable code for the injection procedure.

Coding Tips
Procedures 75801 and 75803 have both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier. For a lymphatic injection procedure, see 38790.
19021-10022
10021 Fine needle aspiration; without imaging guidance
10022 with imaging guidance

Explanation
Fine needle aspiration (FNA) is a percutaneous procedure that uses a fine gauge needle (22 or 25 gauge) and a syringe to sample fluid from a cyst or remove clusters of cells from a solid mass. First, the skin is cleansed. If a lump can be felt, the radiologist or surgeon guides a needle into the area by palpatung the lump. If the lump is non-palpable, the FNA procedure is performed under image guidance using fluoroscopy, ultrasound, or computed tomography (CT), with the patient positioned according to the area of concern. In fluoroscopic guidance, intermittent fluoroscopy guides the advancement of the needle. Ultrasonography-guided aspiration biopsy involves inserting an aspiration catheter needle device through the accessory channel port of the echoendoscope; the needle is placed into the area to be sampled under endoscopic ultrasonographic guidance. After the needle is placed into the region of the lesion, a vacuum is created and multiple in and out needle motions are performed. Several needle insertions are usually required to ensure that an adequate tissue sample is taken. CT image guidance allows computer-assisted targeting of the area to be sampled. At the completion of the procedure, the needle is withdrawn and a small bandage is placed over the area. Report 10021 if fine needle aspiration is performed without imaging guidance. Report 10022 if imaging guidance is used to assist in locating the lump.

19102-19103
19102 Biopsy of breast; percutaneous, needle core, using imaging guidance
19103 percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

Explanation
The physician performs a breast biopsy with image guidance using a percutaneous needle core in 19102, and an automated vacuum assisted or rotating biopsy device, in 19103. In 19102, under image guidance, the physician inserts a large gauge (e.g., 14 gauge), hollow core biopsy needle through the skin of the breast and into the suspicious breast tissue. The physician takes five or more cores of tissue to obtain a sufficient amount of tissue for diagnosis. In 19103, under image guidance, an automated vacuum assisted or rotating biopsy device is inserted through the skin into the suspicious breast tissue and a core of suspect tissue is removed for biopsy. The needle or automated vacuum assisted or rotating biopsy device is withdrawn. Pressure and bandages are applied to the puncture site.

19290-19291
19290 Preoperative placement of needle localization wire, breast;
19291 each additional lesion (List separately in addition to code for primary procedure)

Explanation
Placement of a needle localization wire into a breast lesion is performed to assist in operative identification of the suspect tissue. The physician punctures the skin overlying a breast mass and inserts a needle threaded with a guide wire. Using radiological guidance to facilitate placement, the physician inserts the wire into the mass. Sometimes dye is also injected into the suspect tissue. The wire will help identify a nonpalpable mass that is to be removed from the patient during a separate operative session. Report 19291 for each additional lesion localization wire placed.

19295
19295 Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)

Explanation
The physician places a metallic clip prior to a breast biopsy or aspiration. Using image guidance, the physician places a metallic clip adjacent to a breast lesion to mark the site for a separately reportable breast biopsy or aspiration.

19296-19297
19296 Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy concurrent with partial mastectomy (List separately in addition to code for primary procedure)
19297

Explanation
A remote afterloading balloon catheter for interstitial radiotherapy treatment is placed in the breast following partial mastectomy. Catheter placement is done at a later date, separate from the lumpectomy surgery in 19296, and concurrently with the lumpectomy in 19297. This is a single catheter with a balloon tip that holds the radioactive seed or treatment source, which is loaded and removed for each session. During the lumpectomy surgery, an uninflated balloon catheter is inserted into the recently created tumor cavity and positioned under imaging with a portion of the catheter remaining outside of the body. If a separate procedure is done after surgery, a small incision is first made and the uninflated balloon catheter is guided into position under imaging. After correct placement is determined, the balloon is inflated with saline to fit snugly into the lumpectomy cavity and the breast is bandaged. The catheter remains until radiotherapy treatment sessions are complete.

19298
19298 Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance

Explanation
Using imaging guidance, at the time of a partial mastectomy, or subsequent to a partial mastectomy having been performed, remote afterloading catheters are placed into the breast for interstitial radiotherapy application. The lumpectomy site is identified. A template with pre-drilled holes that function as coordinates for catheter placement around the surgical area may be applied for imaging. Brachytherapy needles are first inserted into the chosen coordinates. The brachytherapy catheters are fed into position through the needles, which are then removed. A catheter button is positioned to hold each catheter in place and imaging confirms their position. These remain in place until the actual loading of the radioactive material for treatment. This code reports only the placement of the catheters.

20220-20225
20220 Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)
20225 deep (eg, vertebral body, femur)

Explanation
The physician usually performs a biopsy on bone to confirm a suspected growth, disease, or infection. The physician normally uses local anesthesia; however, general anesthesia may be used. The physician places a large needle into the spinous process or other superficial bone to obtain the sample in 20220. For sampling a deeper lying bone, such as a vertebra in 20225, an exploring needle is passed through a larger needle to the desired depth and a piece of tissue is removed for testing. Different approaches are taken for vertebral biopsies, based on differing levels of vertebrae. The top three
Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines, both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient’s encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient’s attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital. Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician “admitting” the patient for observation.

Codes 99224-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported. If the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99223, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

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Coding Companion for Radiology